Vacancies									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
Positions not filled permanently	1	Recruitment Plans for all positions in Vacancies Tab	Written plan tailored to MDC to include 1. specifically what activities are undertaken to recruit for each type of position, 2. who is responsible for each activity, 3. when they take place, and 4. how progress is measured including 5. metrics to demonstrate what has been done and the 6. outcome of each. 7. Tailored to MDC means defining why someone would want to work at MDC and why they would want to stay? 8. Examine and analyze why people leave employment at MDC. Identify reasons why people are reluctant to work at MDC. Use this information to improve the reputation and working conditions at MDC.	All plans will be developed and provided within 60 days of OFFER			12/31/2022		
	1A	FILL SITE MEDICAL DIRECTOR AND PHYSICIAN POSITIONS	see Task 1	Plan completed within 60 days to address event of vacancy. Medical director to start and be on site 9.26.22. Physician to start and be on site 10.26.22. If there is a vacancy due to resignation or termination, the position will be permanently filled or functionally filled within 60 days of the vacancy. Functionally filled means: a qualified full-time person has been assigned to the vacant role meeting all the below items: meets the job description, reveived the required training (like what permanent staff will recieve, filly functional in that role (covering similar/full shifts of permanent staff), has no impact on the timeliness and quality of care (measured through CQI and metrics)			12/31/2022		
	1B	Physician and Mid-level positions in event of vacancy	see Task 1	Any vacancy for physicians or midlevel providers which occurs by resignation or termination If there is a vacancy due to resignation or termination, the position will be permanently filled or functionally filled within 60 days of the vacancy. Functionally filled means: a qualified full-time person has been assigned to the vacant role meeting all the below items: meets the job description, reveived the required training (like what permanent staff will recieve, filly functional in that role (covering similar/full shifts of permanent staff), has no impact on the timeliness and quality of care (measured through CQI and metrics) Defendants will notify Plaintiffs of dates of resignation/termination within a week of the resignation/termination.			on-going		

EXHIBIT 2

	2	Recruitment plan for permanent RN positions	See Task #1 Process	5 RN FTEs will be filled with permanent employees by December 1, 2022. If there is a vacancy, the position will be permanently filled or functionally filled within 60 days of the vacancy. Functionally filled means: a qualified full-time person has been assigned to the vacant role meeting all the below items: meets the job description, received the required training (like what permanent staff will recieve, fully functional in that role (covering similar/full shifts of permanent staff), has no impact on the timeliness and quality of care (measured through CQI and metrics)			12/31/2022		
	3	Recruitment plan for Charge Nurse positions	See Task #1 Process, but tailored to nurses with supervisory experience and are ACLS.	The Charge Nurse positions will be filled by December 31, 2022. Any subsequent vacancy due to resignation or termination, the position will be permanently filled or functionally filled within 60 days of the vacancy. Functionally filled means: a qualified full-time person has been assigned to the vacant role meeting all the below items: meets the job description, received the required training (like what permanent staff will recieve, fully functional in that role (covering similar/full shifts of permanent staff), has no impact on the timeliness and quality of care (measured through CQI and metrics)			12/31/2022		
	4	Recruitment plan for Triage Center positions	See Task #1 Process but tailored to the Triage Center. In particular why are these positions separated out? Why are they not part of the pool of nurses who rotate through the assignment? Is there something about the workplace environment that is unappealing? Address any of these issues.	The positions at the Triage Center will be filled BY December 31, 2022. Any subsequent vacancy due to resignation or termination, the position will be permanently filled or functionally filled within 60 days of the vacancy. Functionally filled means: a qualified full-time person has been assigned to the vacant role meeting all the below items: meets the job description, received the required training (like what permanent staff will recieve, fully functional in that role (covering similar/full shifts of permanent staff), has no impact on the timeliness and quality of care (measured through CQI and metrics)			12/31/2022		
	5	Recruitment plan for all other vacant positions.	See Task #1 Process. Tailored recruitment plans may be necessary for other types of personnel; if so they should be developed in written form. A specific plan to reduce the number of positions filled by agency nurses needs to be established.	To provide sufficient personnel to ensure contracted services are delivered on time, are clinically appropriate and safe.			12/31/2022		

	6	Track and report progress with recruitment to MDC.	1. Establish a standing agenda and recurring time to discuss recruitment metrics and outcomes with MDC. 2. Use this information to modify recruitment plans in writing as necessary. 3. Positions that are vacant more than 90 days and vacancies which exceed 15% for any single type of personnel are emphasized. 4. Alternatives to providing the service should be discussed and these decisions documented.	Communicate substantively on recruitment effort and demonstrate results, collaborate in revision of recruitment plans.			12/31/2022		
Interim coverage is insufficient and there is risk of harm.	7	Establish and implement a plan to provide physician services at the site in the interim until the two positions are filled.	1. Secure onsite locum tenums coverage. 2. Consider telehealth coverage for chronic care, H & P, detox, return from off-site care, and/or urgent care medical decision making. 3. Discuss other options for increased primary care coverage with MDC.	Provide relief for the two NPs, reduce back logs and increase physician involvement in planning and provision of patient care, to include securing locum tenums coverage.			12/31/2022		
	7A	Establish back up plan to ensure continuous provision of physician services at the site.	As physcians/mid-level providers may unexpectedly leave employment at the site or a provider may otherwise be unavailable to prevent lapses in care and physician and mid-level care, consider consulting with COCHS to build framework for local providers to fill in gaps.	Consider engaging a consultant to provide consulting on how to build a local provider network (Community Oriented Correctional Health Care (COCHS) is the most obvious resource)-dependent on plan would take this step if necessary			12/31/2022		
	7B	Ensure that in the event of a vacancy or absence, positions in the staffing pattern which deliver clinical care services, including physicians, mid-level providers, nurses, are covered at all times by PRN/locums	Ensure that in the event of a vacancy or absence, positions in the staffing pattern which deliver clinical care services, including physicians, mid-level providers, nurses, are covered at all times by PRN/locums	Within 60 days of offer, Defendant's vendor complies with this provision or Defendant otherwise ensures coverage is provided. On a montlhy basis, the County will provide (1) reports reflecting vacancis and absences of key positions and other clinical staff which include the name of ther person, title, date of vacancy and name of person providing coverage and hours of coverages provided, (2) The monthyly invoices refelcting itemized staffing absence creditsm vacancies of key positions and liquidated damages assessed.			12/31/2022		
Staff morale has been effected by vacancies and turnover.	8	Inform staff of long range recruitment plans and interim coverage arrangements. Provide regular updates on recruitment activities and results.	Inform staff of each recruitment plan, provide metrics to staff on recruitment activities and results. Inform staff of interim arrangements for coverage. Identify and make opportunities for staff to participate in recruitment efforts.	Staff are informed about steps being taken to fill vacant positions and arrangements for interim help.			12/31/2022		

Policies & Procedures									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
Lack of policies and procedures to describe specifically how work is accomplished at MDC.	1	Develop policies and procedures that are specific to MDC.	Map out core processes to include a pre-booking triage etc. Provide core process maps to MDC for review. Make a list of P & P that need to be drafted.	P&P devloped pursuant to this Task will belong to MDC and will not change with medical vendor. Develop P&P that are specific to MDC. At a minimum the topics covered by P & P should coincide with NCCHC standards and conform to MDC policies. Audit tools are developed and used to measure compliance with each P & P.	MDC Contract Compliance Monitor in conjunction with HSA		1/1/2023		
	2	Assign responsibility for managing the initial drafting and annual review of vendor P & P specific to MDC	Suggest this is a responsibility of the Assistant H.S.A. Includes drafting P & P, managing a workgroup to review drafts and provide feedback on needed revisions, making revisions into final form, review finalized P & P with effected staff, document training each staff member received, establish performance expectations and audit tools to measure compliance and competency for each P & P.	Responsibility for managing policy and procedure development, implementation and review is assigned to one individual.	MDC Contract Compliance Monitor		1/1/2023		
	3	Draft facility specific P &P	Use core process maps as the basis for content of the facility specific P & P. Determine who needs to review draft P & P and timeframe in which review can realistically be done. Draft P&P s should go out for review and comment as they are completed. Recommend a process to distribute several at a time for review, establish a timeframe for getting comments back, and process for final approval.	Draft P & P are reviewed by personnel responsible for oversight of the health care program as well as those expected to perform work according to the P & P. A reasonable deadline is established for review and comment. After the review and comment period P & P are finalized.	MDC Contract Compliance Monitor		1/1/2023		

	4	Distribute for review.	Establish a standing work group that meets weekly to receive review assignments, report progress obtaining review feedback, provide comments on drafts, and finalize facility specific P & P. Keep these meetings short (15 min) basically to manage forward progress and accountability to get work done in the interim. Suggested group should be chaired by Assistant H.S.A.; suggested workgroup members are MDC contract compliance monitor, Admin Assist, DON, Nurse Educator, and subject matter experts based upon the topic. Someone from MDC needs to be included on the workgroup so that MDC participates in the review of drafts and provides feedback on needed revisions.	Specific people are assigned to review and comment on draft P & P. They are also responsible for obtaining the review and comments of others (as assigned).	MDC Contract Compliance Monitor		1/15/2023		
Affected parties are not involved in changed processes.	5	Finalize P & P	Sign, date final policies. Set effective date so there is sufficient time to train staff. Suggest finalizing several P & P at a time, usually around a common topic i.e.. Intake P & P and distributing for implementation rather than when all P & P are complete.	Staff have the knowledge, skills, tools and other resources to perform work in compliance with the P & P.	MDC Contract Compliance Monitor in cojunction with medical		2/1/2023		
Staff are not trained sufficiently in new processes.	6	Develop plan to ensure all staff are trained to the P & P.	Training plan needs to address all staff not just shift workers. Methods of training may be different for various types of personnel. The plan should specify what training method will be used to convey performance expectations to each member of the staff, including agency, PRN or locum tenums workers. The training plan must specify when training will be provided, who is responsible and how staff knowledge and ability to perform consistent with P & P will be demonstrated (written test, discussion with supervisor, demonstration etc.) . The plan includes steps to be taken when new staff are brought on to train them on the P & P, evaluate their knowledge and proficiency and document competency to perform in accordance with P & P.	There is a plan to train and implement the P & P with deadlines for completion.	MDC Contract Compliance Monitor		3/1/2023		

	7	Provide training to staff on P & Ps.	Deliver training per the plan. Document completion of training and demonstration of proficiency for each staff member.	Provide training to medical and security staff (as appropriate) on P&Ps. Demonstrate progress implementing P & P.	MDC Contract Compliance Monitor in cojunction with medical vendor		4/15/2023		
	8	Ensure that staff have access to P & P and know where to find them.	Usually this is on a shared drive. Knowledge of where to access P & P should be spot audited.	P & P are available and staff access them.	MDC Contract Compliance Monitor		2/1/2023-rolling deadline as policies are finalized		
	9	Audit performance consistent with P & P, provide feedback and take action to improve.	Each P & P has an audit tool developed while the policy is being drafted to measure performance in compliance with the P & P. Audit tools may include observation, chart review, review of logs or other documentation, tests of knowledge etc.	Individual performance is monitored by supervisors. Supervisors provide individual and group training and coaching to improve staff performance. Program performance measures are audited and reported at CQI meetings. Plans to improve performance are developed based upon audit results.	MDC Contract Compliance Monitor in cojunction with medical vendor		04/15/2023		
	10	Establish schedule and methodology to conduct the annual review and revision of P & P.	Review and revision of P & P does not need to be as elaborate as the initial development and implementation. However it does need to include review of audit findings, consider process improvements, and solicit input from affected parties. Revised P & P need to be distributed and staff informed of changes to P & P. Verify staff knowledge and competency to perform consistent with P & P annually and documented as part of performance review.	P & P are current and staff know performance expectations.	MDC Contract Compliance Monitor in cojunction with medical vendor		1/1/2023		

	11	Other written guidelines need review, may need revision, and periodic verification that staff have been trained and are competent to perform the work as expected.	List other written guidelines used to guide staff performance such as nursing encounter tools, nursing intervention guides, clinical guidelines, and infection control. Assign persons to be responsible for each. Use steps 1-10 to manage review, revision, documentation of training and performance competency for other written guidelines .	Set review schedule so that Other written guidelines are current and staff know performance expectations.	MDC Contract Compliance Monitor in cojunction with medical vendor		1/1/2023		
	12	Report progress on revision of written guidelines referenced in Topic #11.	Progress is reported on the development, review and revision of written guidelines as a standing agenda item at CQI meetings. These reports include progress training staff and establishing competency. A dashboard with benchmarks should be developed to visually show progress toward deadlines.	Report progress on revision of written guidelines.	MDC Contract Compliance Monitor		2/1/2023		

McClendon									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
Defendant and its vendor have not achieved compliance with the McClendon Settlement Agreement	1	Establish a McClendon Core Process Program	The County and its Vendor will implement a MEAC team. This includes County employees and YesCare's "dedicated personnel specificially assigned to oversee decree compliance" and other participants identified by the County and vendor. See 4.1.28.2 for outline of vendor's commitment to process.	The vendor has a clear plan for a process to measure their performance in relation to the Settlement Agreement. Plan to be in effect and provided to County and Parties.			1/15/2023		
	2	Establish and identify team members.	The Duvall Team included a manager and coordinator for the process of improvement, a data analyst, an RN auditor, and Director of Operations. Determine what roles and responsibilities for each McClendon team member. Identify persons for each role on the team. Orient, train and familiarize each team member with their responsibilities and the role of others on the team. Familiarize selves with the McClendon Settlement Agreement and the Check Out Audit. Review the Monitor's April 2022 report and subsequent report. Determine, in consultation with the Monitor, the areas to be audited and at what frequency.	The Monitor agrees with the vendor's plan and tools to monitor their performance.			1/15/2023		
	3	Develop audit tools to evaluate performance in relation to the items in the Settlement Agreement	Develop audit tools with the input and final agreement of the Monitor. Audit tools 1. define what the goal of the audit is, 2. describe how the sample is selected and the 3. size of the sample. 4. Audit questions are developed and used to review records or observe the process of care delivery. 4. Performance thresholds are established and 5. terms defined. 6. The method to score performance against the threshold is defined.	See Column D			1/15/2023		

	4	Pilot audit tools and evaluate results. Revise tools based upon evaluation to increase validity and reliability.	Personnel who are responsible for performing the audit and the analysis of results pilot the tools to determine if they measure what was intended and that the data is meaningful and reliable (the same results would be achieved by another auditor). Revise tools as necessary to clarify terms and processes and improve sample selection.	See Column D			1/15/2023		
	5	Establish the audit calendar.	Determine the minimum times each audit will be performed annually (more frequent in the beginning) in consultation and with the approval of the Monitor. The frequency of each audit may reduce as sustained performance is demonstrated.	See Column D			1/15/2023		
	6	Assign and conduct audits per schedule.	The audit results are presented monthly to the leadership team and discussed. The results are also provided to the Monitor by the leadership team and discussed. The audit teams' summary of results also includes recommendations which are discussed with leadership to determine action plans to address findings.	Plans to correct or improve performance are developed as a result of the audit results and analysis of performance.			1/15/2023		
	7	Prepare a biannual report of performance.	The report summarizes results for each six month period, action plan steps taken and outcomes achieved. Areas of attention for the subsequent six month period are described. The report is provided to MDC and the Monitor.	The biennial report is provided in advance of the Monitor's site visits and his compliance report.			1/15/2023		

Collaboration & Communication									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
Staff need information and training to support changes that are necessary to improve health care at MDC.	1	Communicate outcomes to be achieved from the vendor's plan for change, the agreed upon CAP and expected timeframes to staff.	Plans for changed processes at MDC are communicated in written and verbal form. Health care leadership use the operational huddle to identify information staff need to have on a daily basis and ensure all members of the leadership team have the same information so the message is consistent at all organizational levels. Information is provided verbally and in writing at staff meetings. Minutes of meetings are taken, distributed and widely available for review. Progress accomplishing change is displayed visually so staff can see at a glance what has been accomplished and what is left to do.	Staff are knowledgeable and engaged in necessary change at MDC.			12/31/2022		
	2	Establish a daily operational huddle to inform and manage the daily process of service delivery. Physician/mid-level provider on shift and charge nurse on shift will participate. Information from the huddle will be made available to providers, charge nurses, and	Members of the huddle need to know the status of each area of service delivery, the priorities of the day for each member of the leadership team need to be communicated, needs for assistance with daily tasks identified and resolved. Review the standing agenda for the daily operational huddle with the Monitor to ensure it addresses the areas that need to be covered daily.	Provide standing agenda and daily sign-in sheets for daily operational huddles to Plaintiffs on the first and fifteenth of each month (bi-montly basis) beginning 90 days from date of offer. Sign in sheets must indicate the credentials and titles of each participant and a physcian or mid-level provider must participate in each huddle.			12/31/2022		

Patients have been harmed because information was not shared between treating providers.	3	Establish a memorandum of understanding or working agreement with the vendor responsible for MAT and ATP regarding information sharing and access to patient information.	Define clinical information that each party needs to make available to the other in the care and management of shared patients and the mechanism to make this information available. Information that needs to be "pushed" to the other party should be delineated from that which is available as needed in establishing mechanisms for exchange of information. Implement the agreement.	Patient safety is ensured because important information is provided when treatment decisions affect other care the patient is receiving. MOU shall be memorialized to include: Medical vendor shall, 1) at a minimum report patients' current MAT medications to MAT vendor within 4 hours of intake (intake is defined as medical intake and recieving screen) 2) Evidence attempts to verify MOUD ASAP after intake and no later than 12 hours. Policy should include timeslines for following up and escalating. The 12 hours is to accomodate out of state perscriptions. Because 80-90 percent of people will be instate, other attempts should be sooner. 2A) If a patient reports non-prescription suboxone use in the community, vendor also reports this including any information about amount and last use to MAT vendor 3) All vendors must have access at all times to information about what Rx medication an individual is on, the dosage, and the Dx it is used to treat. 4) All vendors have access at all times to information about a patient's "problems list" and vital signs. 5) the rational for denial or discontinuation of medical treatment must be documented. 6) Any patient withdrawing from MAT or other substances recieves medically managed withdrawal. 7) MAT vendor shall at a minimum provide MDC and medical vendor daily with a. documentation of date/time/amount of dosing for each patient receiving MAT, b. documentation of rational for any denial or discontinuation of MAT to any MDC inmate. This documentation shall be made a part of each inmate's primary MDC medical file. 8) the MOU will contain other information treating providers and Defendants identify. 9. MOU will identify what needs to be "pushed" and will establish mechansims for exchanging pushed information as needed.			12/31/2022		
	4	Participate in the Health Information Exchange	Identify the status of this program in Albuquerque and criteria for participation. Identify the steps necessary to participate and proceed with a plan to attain participation status.	Participate in the HIE with a bi-directional interface. Any EMR will interface directly with the NM Health Information Collaborative.			12/31/2022		

Communication between officers and health care staff is not always timely and responsive.	5	Increase opportunities for meaningful communication and dialogue between officers and nurses regarding health matters.	MDC has provided training for officers on common medical emergencies. However there are still instances of poor communication by both officers and health care staff. This task is to initiate an effort to regular communication between officers and Med 1 nurses when there is no urgency. An example would be to have the Med 1 nurse (assume they rotate through this assignment) and one of the charge nurses attend roll call once a week or some other regular schedule. The purpose for attending is to create a regular opportunity for dialogue, to provide information, answer questions, hear concerns, or provide a brief training. Another process could be substituted for the one described here but it needs to include participation by line staff responsible for responding to officers reporting urgent or emergent concerns about health conditions. Another alternative is to have a Med 1 nurse responsible for health related part of annual officer training. The same could be said to improve communication both ways between nurses assigned detox rounds and officers.	Create plan for increasing communication between security and medical to include either Med1 participation in roll call once a week or to provide annual training in order to ensure Communication between line staff is timely, accurate and responsive. Implement plan and provide plan to Plaintiffs-				12/31/2022-create 1/31/2023-implement	
	6	Missed opportunities to communicate relevant information about a detainee's condition are considered in every emergency debriefing and adverse patient safety	Emergency response evaluation tools and adverse event reviews are revised to identify and reflect on missed or poor communication. These are trended and used to develop improvement projects.	1. Create/revise emergency response tools for adverse events to identify/reflect on missed or poor communication; 2. Trend and use emergency response tools to develop improvement projects	Natalie Vance		12/31/2022-create 1/31/2023-implement		

Automation									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
The new vendor introduced a new electronic health record.	1	Define the expectations of staff use of the electronic record.	List and describe the features of the electronic record staff are expected to be proficient with. This may vary by type of position. Features include how information is entered into the record, how tasks and patient care are tracked, how to identify work that needs to be done, and how various reports are developed and what they are used for. This is equivalent to a user manual or curriculum to train new staff. Inform staff of specific expectations regarding proficiency in use of the electronic record.	The processes that are followed to enter and retrieve information from the electronic record are in written form and available for use as a reference, for building proficiency among users and to train new staff. Expectations for proficiency in the use of the electronic record have been made clear to staff.			9/23/22 (60 days from offer)		
Staff are not yet proficient in use of the new electronic record.	2	Assess proficiency staff currently have using the features of the electronic record.	Assess staff proficiency performing tasks with the electronic record to identify skills or knowledge that needs remediation by re-training, coaching, etc. Survey staff as to the impediments they experience using the electronic record. Identify staff with superior skills and enlist their help working with others who are less capable. Identify needs for additional support in use of the electronic record.	Staff will be provided with training, coaching and other assistance (quick guides, checklists etc.) to attain expectations for proficiency.			10/24/22 (90 days from offer to allow for survey)		
	3	Bring staff proficiency in use of the electronic record to the level defined in task 1 above.	Develop plan to improve staff proficiency based upon the assessment and survey results. Share plan with MDC for endorsement and set deadlines and benchmarks. Share plan with affected staff. Implement plan, document training, coaching and remedial support provided. Revaluate skills and knowledge. Report progress and results at staff meetings, leadership meetings and to MDC.	Provide evidence that all staff are receiving training and skill building according to a plan.			11/25/22 (120 days from offer)		

	3A	Agency staff are not proficient in use of the EMR, including use of NETS, etc	Develop a plan to ensure that all agency staff are proficient in use of the EMR to the level defined in task 1 above.	same as lns 2 and 3			9/23/22 (60 days from offer)		
There are problems with the accuracy and completeness of information in the new electronic record.	4	Identify problem areas in use of the electronic health record to manage patient care.	Problem areas identified to date include incomplete or inaccurate problem lists, identification of patients with chronic disease, lists of patients needing to be monitored for one or more conditions (i.e. detox), inability to track completion of tasks - i.e. order implementation, prioritization of urgency for scheduling follow up and specialty care, incomplete history, physical exam, and plan of care and failure to provide information about the patient to providers in the community.	Prioritize and manage the work needed to address issues with the use of the electronic record. Provide Plaintiffs with report on problems identified and plan to remedy.			11/25/22 (120 days from offer to allow for survey)		
	5	Identify methods to address each problem area identified.	Evaluate workflow and navigation in the electronic record for each identified problem area. Review and assess the templates in use and revise as necessary to increase clinical detail and documentation of the plan of care. For each problem area evaluate root causes and human factors that are contributing. Identify solutions for each problem area and what steps will be taken to eliminate it or minimize its impact on patient health and safety. Report progress to leadership weekly and summarize progress at staff meetings. Develop "work arounds" until the problem has been satisfactorily addressed.	Provide evidence that problem areas are being addressed and to communicate solutions.			12/31/2022		

Staff need information from the electronic record to plan and manage the flow of patient care.	6	Identify information needed to manage and monitor patient care	Identify information about patient care that needs to be tracked, reviewed and monitored. Determine the content and frequency of each report (by shift, daily, weekly, monthly etc.). Determine the distribution list for each report, the person responsible for running the report, the person(s) responsible for reviewing the report and by when.	eOMIS provides information and reports to monitor and manage the provision of patient care, reports are generated, distributed, monitored, and acted on appropriately by the identified health care staff.			12/31/2022		
	7	Provide information	Build lists as identified in 6. Use of lists will vary depending upon purpose. Periodically monitor whether information routinely available is accurate and serving the intended purpose; revise as necessary.				12/31/2022		

Medical Emergency Response									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
Emergency equipment and supplies are not always available at the time of a man down call.	1	Establish a process to ensure that appropriate equipment and supplies are available and functional when responding to medical emergencies.	a. Establish a list of equipment and supplies that is to be available during every emergency. This list should include material that is taken when responding to the site of an emergency and material that is stationed in the clinic. b. Determine the quantities to be on-hand and re-order levels for each item. c. Establish procedures and quantity of material so that a crash cart/emergency man down bag is always available. This may mean having multiple carts/bags if there are multiple simultaneous emergencies and capacity to restock quickly. d. Establish procedures to check at each shift change the integrity of the crash cart/man down bags, the availability of items not in the crash cart/man down bags (neck collar, back board, stretcher, WC etc.)the functionality of equipment (AED, suction, O2 etc.) and availability of supplies (O2 sufficient quantity etc.). e. Assign responsibility for maintaining equipment and supplies, restocking , checking availability and functionality at shift change. f. Provide documentation that emergency equipment and supplies are sufficient and functional on a daily basis. Documentation should include porcedures and checklist.	Sufficient equipment and supplies are available and functional for response to every emergency. Implement steps in Column D.			12/31/2022		
Lack of finalized policy and procedure for medical emergency response.	2	The response to medical emergencies is consistent with a facility specific policy and procedure which aligns with MDC PNP HCA 12.37.	Map out the desired process for preparation and response to medical emergency. Identify steps that need to be taken to achieve the desired process, with benchmarks and deadlines. Allow for staff input into the desired process as well as input and review by MDC. Finalize the process into written facility specific policy and procedure. Provide evidence that staff are knowledgeable of the P & P.	The response to medical emergencies is prompt, consistent with policy, procedure and other written guidelines and community standards. Implement steps in Column D.			12/31/2022		
Health care staff are unfamiliar or unpracticed in responding to medical emergencies.	3	Train staff in emergency medical response.	Provide evidence that all other staff expected to respond to medical emergencies are trained to do so. This includes at a minimum health provider BLS, assessment and response to common emergencies, the ERTs, clinical indicators and procedures for contacting providers, accessing EMS, transport to the ED, documentation and debriefing the response. There is documentation that each staff has the knowledge and demonstrated skill in responding to medical emergencies.	The response to medical emergencies is prompt, consistent with policy, procedure and other written guidelines and community standards - this is accomplished through training and established with documentation that each staff member (or agency staff) has the documented knowledge and skill in responding to medical emergencies.			12/31/2022		

	4	Initiate the plan to achieve a 4 minute response to medical emergencies by an ACLS trained provider.	See Final Negotiation Letter, Exhibit C changing section 4.1.2.3.6 of the RFP. Also implement the expectation that the Medical Director (or designee) attend the monthly meeting of the City of Albuquerque Medical Control Board.	Provide plan to achieve a 4 minute response to medical emergencies by an ACLS provider and a roster of all staff who are ACLS certified. On a montly basis provide Expert and Plaintiffs shift rosters demonstrating that there is an ACLS provider scheduled for each shift.			12/31/2022		
Telephone notification of medical emergencies sometimes fails and delays care.	5	Conduct a root cause analysis as to why communication between medical and security is not always effective to initiate emergency responses when appropriate: Evaluate equipment and processes for notification of a medical emergency and eliminate factors that cause delays in such notification.	Telephone does not always appear to be reliable for notification of a medical emergency. The evaluation needs to include consideration of why these failures occur and identification of corrective measures to ensure prompt notification and response. Careful consideration should be given to having redundancy in the process to prevent delays or failure. For example, if security calls Med 1 and there is no answer, have Med 1 phone roll to Med 3. Or if security calls Med 1 and there is no answer, security is to immediately call on the radio for medical assistance.	include evaluation of secuity coordination and if there is a problem, will look at fixing it d- changed . Security will use the telephone and/or radio to intiate emergency medical responses. Medical will always answer the phone and radio and respond appropriately.			12/31/2022		
There are delays in follow up and continuity of care upon return from the ED or hospital after having a medical emergency.	6	Persons receiving off site emergency care are seen by a practitioner within 24 hours of return to the facility. (Note: If telehealth were increased elsewhere the onsite mid levels should be prioritized to do this.)	Establish a process that ensures patients are brought to the medical clinic after return to the facility, the patient is assessed and the discharge paperwork reviewed, orders for continued care obtained, ordered care is initiated, and the follow up appointment scheduled to take place no later than the end of the next day. The follow up appointment with the patient is in person (telehealth could be considered here) and includes a review of the patient's condition, findings and recommendations from the ED or hospital and documentation by the practitioner of the plan of care, including rationale for not following any recommendation from off site providers.	There are no delays in follow up or discontinuity in care when patients experience a medical emergency. Patients are seen by a practitioner (MD, PA, NP) within 24 hours of return to the facility from off-site care.			12/31/2022		
	7	Identify information needed and generate reports so that managers and clinical leaders are knowledgeable about medical emergencies, the response, and ensure that follow up care is timely and appropriate.	a. A log should be kept or report obtained listing any patients who have been responded to emergently. Information should include presenting symptoms, time of notification, time of response, names of those who responded, whether a provider was contacted, whether EMS was contacted and if the patient was transported the time and destination, and the outcome (time of return, hospitalization, or death). b. This information would be reviewed at the daily operational huddle and assignments to monitor the patients care and follow up appointment made. c. A more thorough review of the record should be completed by the DON that day and any issues identified reported to the appropriate leadership personnel and corrective action taken as necessary. This review and corrective action should be documented. d. A member of the leadership team has a regular assignment to monitor completion of the emergency response equipment checks and emergent urgent services log. Any issues with emergency equipment or supplies is brought up at the daily huddle for resolution.	a. keep an emergency log or produce a report as described under process for achieving tasks. B. review at the daily huddle C. DON conduct reviews as described in column D. D. monitor completions of logs			12/31/2022		

	8	Emergency response is audited for timeliness and clinical quality.	Develop an audit tool that evaluates the readiness for response to emergencies, timeliness of initial notification and response, whether the appropriate equipment and supplies were brought to the site, whether the steps outlined in P & P and the ERTs were followed, whether a staff trained in ACLS responded etc. Audit results should be provided in feedback to individual staff and in aggregate to CQI with trending and analysis. The Monitor should have input and approve the audit tool, including sample selection and audit frequency.	Emergency response is audited for timeliness and clinical quality.			12/31/2022		
	9	Develop a process to clinically review medical care in the months prior to a medical emergencies for ambulatory sensitive conditions to determine if there are opportunities to improve primary care	Develop a clinical audit tool that evaluates patients who have had emergent episodes of care for ambulatory sensitive conditions (seizure, alcohol and/or substance withdrawal, skin or deep tissue infections, DKA, abdominal pain, or chest pain) to identify opportunities to improve primary care in the three months prior. Audit results should be provided in feedback to individual staff and in aggregate to CQI with trending and analysis. The Monitor should have input and approve the audit tool, including sample selection and audit frequency.	Audit and tracking: Develop a process to clinically review medical care in the months prior to a medical emergencies for ambulatory sensitive conditions to determine if there are opportunities to improve primary care			12/31/2022		
Mortality review process is not well established at MDC	10	Establish a comprehensive, timely process to review every death and morbidity event to identify opportunities to improve the system of care.	Every morbidity & mortality review should include a description of the emergency (if applicable) and the corresponding response. Steps need to be taken to review care antecedent to the medical emergency or morbidity to determine if there are opportunities for improvement in the patient's care during the period of detention at the jail. The results of these reviews are used by supervisors to provide feedback and coaching of individual staff. Aggregate results are analyzed and trended for discussion by the CQI committee. Improvement plans are used to guide improved processes and performance. The Monitor should be consulted on how to develop a process for thorough review of deaths and morbidities as part of the M&M process. There should be a defined process to report and track deaths, medical emergencies and morbidity events that require an M&M review.	All deaths and morbidities (including but not limited to serious injury requiring hospitalization, inention or unintention overdose/suicide attempt, serious illness/complication from illness, CPR performed, complications from procedures, instance of permanent patient harm, prolonged hospitalization not related to the natural course of the patient's illness, when intervention is required to sustain life) are reviewed promptly in a comprehensive morbidity and mortality format that includes participation by MDC. Opportunities for improvement are identified in the immediate response as well as antecedent care provided. Documentation of results, analysis, and feedback and coaching for individual staff is documented. Establish process for medical staff to report and track incidents likely to need an M&M review. Staff designated to perform M&M reviews should meet monthly to review incident tracking list, designate incidents for formal review and being review process. M&Ms should be completed within 3 months of incident. M&M reports provided to Expert and Plaintiffs monthly.			12/31/2022		

Intake Screening									
Issue	**Task #**	**Task**	**Process For Accomplishing The Task**	**Expectation**	**Responsible Party**	**Start Date**	**Deadline**	**Percentage Complete**	**Completion Date**
The timeliness and accurateness of intake screening needs improvement.	1	Use the Core Process for intake to identify factors causing intake screening to be untimely.	Map the current and desired steps in intake screening to include pre-booking and the identification of persons who cannot be accepted for detention until cleared by a medical center, those who need urgent medical attention and those who require medical monitoring for withdrawal management. Identify steps taken to triage and prioritize intake screening for individuals who need urgent medical attention or withdrawal management. Assess the physical location, tools available and privacy provided for intake screening. Evaluate the template used to document intake screening to ensure that screening is sufficiently comprehensive to identify individuals with infectious disease, continue treatment that was initiated in the community, initiate care for other identifiable conditions that require medical attention, and arrange for safe housing and appropriate medical follow up. Assess the education, training and degree of clinical supervision provided to develop skills to perform intake screening.	Complete and meaningful Intake screening is accomplished no more than four hours after arrival at RDT or the triage center, whichever is sooner, and is completed by an appropriately licensed and supervised medical worker. Provide Expert and Plaintiff documentation of the template evaluation, and any CAP			12/31/2022		
	2	List the steps to be taken to accomplish timely intake screening.	Review these steps with MDC to obtain support for needed changes. Review process changes with affected staff to enlist their cooperation. Provide training, equipment and needed to ensure timeliness of intake screening. Establish performance expectations for timely, thorough intake screenings and assess staff competency to perform intake screening. Document this evaluation and periodically repeat the evaluation of competency.	Provide listed steps to Expert and Plaintiff. Priovide documentation of process changes, performance expectations, and competency evaluations			10/24/22 (90 days from offer)		
	3	Monitor and supervise the intake process.	The intake core process needs to include methods of informing management of the status of the intake queue to include the numbers of priority individuals in intake and how long they have been there. Individual staff should be identified for assignment to intake when there is a delay in intake screening. A manager (Charge RN) needs to be readily available to facilitate intake screening throughout the shift. Establish mechanisms for prospective reporting from intake. Intake numbers and screening status should be reported at least beginning, middle and end of shift. Arrangements need to be made in advance to handle surges in intakes (standby staff, availability of providers, clerical assistance with ROIs etc.).	Implement processes in Column D			12/31/2022		

	4	Ensure that medication verification is completed timely and bridge medication initiated.	This task requires that staff have a method to verify medication, are trained and proficient in its use, and are aware of the priority for medication continuity. Establish a metric that makes clear the timeframe in which this is to be accomplished and who is responsible for each step in getting bridge orders initiated.	There are no missed doses of medication once intake screening takes place. This applies to medications provided by any vendor prescribing medications (e.g. YesCare, RSNM). Provide Expert and Plaintiffs with the metric making clear the time frame and the method(s) used to verify medication.			12/31/2022		
	5	Information from Sapphire is not updated in eOMIS after readmission to MDC or for those who have been incarcerated since before the October 2021 vendor/EMR change.	A process needs to be established to abstract the Sapphire record for information about each detainee's health status and diagnosis as part of intake screening. Important information would include diagnoses, chronic clinic notes, any hospitalizations or ED visits, any off site specialty care recommended or provided, last medication administration record. This could be accomplished by medical records staff the day following intake. The abstract information should be reviewed with a provider who will determine what information should be added to the eOMIS record and incorporated into the continued care of the patient. This necessity of this process can be revisited as time passes and the information in Sapphire is less relevant.	Medical records will be complete and include pertient information from Sapphire and eOMIs (past incarcerations). Medical staff, including providers, will have access to and know how to access Sapphire. Documentation of the process is provided to Plaintiffs and the Expert. This information will be updated in the patient's eOMIS record the day following intake.			12/31/2022		
	6	Audit the timeliness, thoroughness and quality of clinical assessment and decision making in intake.	Establish an audit tool for the intake process. Audit questions should concern whether each step was completed timely (medication verification, orders obtained, alerts entered, treatment initiated, safely housed), whether the information obtained was thorough (follow up questions asked to amplify answers), accurate, and comprehensive. Also if the steps taken to initiate plans for care were clinically appropriate. This audit should be completed by Charge Nurses weekly until performance is improved and sustained. Audit results should be presented and discussed at weekly leadership team meetings. Near misses in intake screening identified using the audit tool should be reviewed to determine opportunities for improvement with staff affected and discussed at CQI meetings.	Persons are identified who need medical care and appropriate timely care initiated. Audit tool is developed and timeliness, thoroughness and quality of clinical assessment and decision making in intake is audited.			12/31/2022		

Information is not available at and after intake	7	Establish an intake screening process that allows intake to access medical histories, and to have the information available to medical following intake.	Establish an intake screening process with MDC that allows medical staff to review a patient's history and allows the input of all information into a single medical record thereby eliminating the need entirely for later merging medical intake repcrds with an OMS file and historical medical record. If such a process cannot be estabiuied, the medical vendor shall ensure that all intake screenings and temporary "T" numbers are merged with corresponding OMS and historical medical records within 24 hours of a patient's arrival at RDC. Medical intake shall ask and record whether a patient has been booked under any other name to ensure maximum information is available.	See Column D - Provide Expert and Plaintiffs with a concise explanation of the plan and process			12/31/2022		

MAT & Withdrawal Management									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
The number of inmates on withdrawal protocol exceeds the space available to safely monitor their condition.	1A	Evaluate the resources needed for constant monitoring in the context of the population requiring withdrawal management.	Document the process for medical to communicate withdrawal status and need for a watch to security. Consider this being more than the provision of an MDC-42. Charge nurse and shift commander confer each shift to identify individuals withdrawing from substances and confirm officers/watchers for watch.	Persons being monitored for withdrawal symptoms are always housed where constant monitoring is provided. Individuals housed in cells have watcher who is separate from the pod officer. Any pod housing individuals who are withdrawing from substances cannot be left unattended at any time.			12/31/2022		
Improve patient care through medical-security communication.	1B	Review and revise withdrawal protocols for all substances to determine whether they are appropriate given local patterns of substance use and withdrawal.	Determine if protocols are appropriate given local patterns of substance use withdrawal and revise if needed. (Corporate and MDC should do this). Educate, train, and coach custody staff responsible for monitoring people in withdrawal and demonstrate that staff with these responsibilities are proficient and competent in this process of care.	Withdrawal management processes are consistent with the community standard of care and are provided to the Addiction Treamtment Advisory Board for review.			12/31/2022		
Improve patient care through medical-security communication.	1C	Educate both medical and security staff of the life-threatening nature of withdrawal symptoms and eliminate the mentality that people are "just detoxing." Ensure that health care staff are contacted by security when persons on monitoring demonsrate symptoms.	Create a FAQ or information sheet to be posted at officer desks in pods with any individuals withdrawing that identifies signs and symptoms of withdrawal, the dangers, and when to contact medical and when to call a Code-43 or Code Blue. Counsel security that waiting for detox nurses to round is not alway a sufficient response to witnessing an individual exhibiting symptoms (e.g. repeated vomiting, shaking). Counsel medical staff that they must respond appropriatly when security or other medical staff contact them regarding a patient exhibiting withdrawal symptoms. If the decision is made to wait until the next detox round for the LPN or any medical staff to assess that patient, the clinical rational must be documented by the appropriate decider either in the MED-1 log or via patient note.	Health care staff are informed by officers when persons on monitoring demonstrate symptoms and medical uses appropriate clinical decision making to see the patient timely in response. See Column D.			12/31/2022		

Improve withdrawal management processes.	2	Define the immediate work plan for the Addiction Specialist and obtain MDC endorsement.	In lieu of receiving a written work plan as described by Ms. Knox, the County shall make Dr. Stacy available for a meeting with Plaintiffs to last up to two hours to discuss withdrawal treatment and SUD issues. This meeting is separate from access meetings. Following the meeting with Dr. Stacy, a written work plan will be provided. The County will also make Dr. Stacy available for some, but not all access meetings with reasonable notice (more than 48 hours) of the agenda.	Withdrawal management processes are consistent with the community standard of care.			Meeting to be set ASAP and no later than 12/21/22		
	3	Provide methadone and suboxone consistent with Section 4.6.5 of the County's RFP.	A. Begin providing suboxone for withrdawal management as set out in the contract and consistent with community standards of care B. Ensure provision of methadone or subxone within 24 hours of intake (see Medication Management) either through bridge order or MAT vendor for those entering current on medications. C. Revise P&Ps to comply with community standards of care for MAT inductions. And comply with all other provisions of 4.6.5	See Column D. All medication administered or denied for withdrawal management, including suboxone and methadone, will be documented in each inmate's medical file or EMR (YesCare or primary MDC medical vendor) and included on the detox list.			12/31/2022		
	4A	Clearly define the parameters for referral to practitioners, expectations for direct practitioner-patient contact during withdrawal, and clinical oversight of nursing staff who complete withdrawal assessment.		Implement parameters and ensure any necessary changes are made to P&Ps regarding withdrawal manamgement. Provide documentation to Parties and Expert			12/31/2022		
	4B	Obtain a certified addiction specialist on staff at MDC.	This was a recommendation of Dr. Stern representing the Addiction Treatment Advisory Board during the vendor selection process. One of the existing psychiatrists should be engaged and assisted ($) to obtain this certification. This psychiatrist should participate and provide clinical oversight for withdrawal management and addiction treatment.	Addiction specialist on-boarded/certified. Addiction specialist provides clinical oversight of withdrawal management and addication treatment. Participation in clincial management is documented. Any subsequent vacancy is filled within 90 days with corporate providing support in the interim.			12/31/2022		

	5	Improve the accuracy and timeliness of withdrawal symptom assessments and treatment.	1. Educate, train, and coach staff responsible for assessing and treating symptoms of people in withdrawal and demonstrate that staff with these responsibilities are proficient and competent in this process of care. 2. Ensure that assessments include inquiry of the correctional officer responsible for monitoring the patient, provision of hydration, and inquiry of the patient about suicide or self harm. 3. Documentation in the EMR should take place as the withdrawal assessment is being completed. If this is not happening, develop a plan to achieve contemporaneous documentation.	Staff performance is consistent with expectations and tasks outlined in column D have been accomplished.			1. 12/31 ; 2. 1/15/23; 3) 1/31/2023		
	6	Establish, in consultation and approval of the Monitor, an audit tool that captures all of the steps in the withdrawal process. Audit withdrawal management.	The audit needs to include timeliness, quality of assessment and communication of results, appropriateness of decision making and the plan of care. The audit should also coincide with clinical guidelines for withdrawal management and facility specific P & P. Audit frequency should be based upon risk to patient safety. More frequent spot audits using portions of the tool may be used to accomplish rapid change and feedback where necessary to promote process improvement. There should also be a schedule and assignment to randomly observe withdrawal assessments in person and via remote camera. Results of these audits are used by supervisors to provide feedback and coaching of individual staff. Aggregate results are analyzed and trended for discussion by the CQI committee. Improvement plans are used to guide improved processes and performance.	Audit is developed and Barriers to safe and effective withdrawal management are identified and addressed through audits, use of audit data, and improvement plans.			12/31/2022		
Monitor and manage withdrawal workflow.	7	Pertinent information is available and used by leadership to manage the workflow of withdrawal management.	Information needed includes the number of patients in withdrawal, a measure of their acuity, likely time left on the withdrawal protocol, the particulars of high acuity or deteriorating patients, and any issues encountered in the previous 24 hours and the outcome. This information needs to be reviewed at the daily operational huddle and is included in the change of shift report between nurses assigned to withdrawal protocols and the shift change nurses. Clear parameters are defined for when escalation up the chain of command is to take place.	Reports containing the necessary information, to include that set out in column D, are generated and reviewed daily			12/31/2022		

Intake receiving screening does not contain sufficient information for medical decision making	8	Intake receiving screening sufficient information for medical decision making	Revise intake receiving tool to include 1) date AND Approximate TIME of last use of any substance; 2) subjective information about previous withdrawal symptoms (e.g. seizures, hallucinations, DTS, suicidality) relevant to particular type of withdrawal. This is to be revised with the instruction of Dr. Kumar; 3) whether currently on methadone, suboxone, or vivitrol, and if yes the dose and the provider.	Revise intake receiving tool to include 1) date AND Approximate TIME of last use of any substance; 2) subjective information about previous withdrawal symptoms (e.g. seizures, hallucinations, DTS, suicidality) relevant to particular type of withdrawal. This is to be revised with the instruction of Dr. Kumar; 3) whether currently on methadone, suboxone, or vivitrol, and if yes the dose and the provider.			12/31/2022		
	9	Withdrawal medications are not initiated or provided timely	It is critical to start withdrawal medications and comfort medications timely - generally this is before the on-set of withdrawal symptoms. Given the timing of admissions and rounding, providers should be contacted at admission for orders.	Need to see current SAW to determine what steps			11/22/22 (120 days from offer)		
	10	COWS/CIWA-AR scores do not accurately reflect patient's withdrawal symptoms	1. Retrain detox nurses on COW/CIWA-ar questions and meaning of symptoms an ensure competency 2. Supervise/observe/audit detox nurses to ensure assessments completed appropriately 3. Revise Flowsheet to reflect the questions to ask to assess COW/CIWA-ar scores 4. Audit documentation to ensure any score is supported by data (e.g. the current electronic scores state a number, but do not reflect what that number is based on)	Complete tasks in Column D to ensure patients are being assessed appropriately for withdrawal symptoms			11/22/22 (120 days from offer)		

Sick Call									
Issue	**Task #**	**Task**	**Process For Accomplishing The Task**	**Expectation**	**Responsible Party**	**Start Date**	**Deadline**	**Percentage Complete**	**Completion Date**
Requests for health care attention are not responded to timely.	1	Use the Core Process for sick call to identify factors causing untimely responses to patient requests for health care attention.	Use results of the core process assessment to identify interventions to improve timeliness. The resulting process should include ensuring availability of sick call forms on the housing units, daily pick up of requests, immediate triage to determine whether the request is an administrative matter that can be addressed without seeing the patient (i.e.. request for medication refill) or the complaint is symptomatic which requires a face to face encounter and the urgency with which it is to take place. Requests determined to have emergent priority are seen immediately after triage, urgent requests no later than end of the day and routine requests no later than the end of the next day. All requests are entered into the electronic health record when received, the urgency is also indicated and encounters scheduled according to urgency. Clerical assistance with data entry and scheduling needs to be considered.	Requests for health care attention are responded to timely, requests are entered into the electronic health record when they are received, and the urgency is indicated and encounters scheduled with the appropriate level of medical staff acording to the urgency.			12/31/2022		
	2	Improve information available to manage workflow necessary to respond appropriately to requests for health care attention.	At the beginning of the shift the DON and charge nurse need to know how many requests have been received, how many need to be seen by level of urgency and how many requests received the day before still need to be seen. They also need to know how many requests will be addressed administratively. This information is used to staff the work that needs to be done that day. As the day progresses they need to know how many are yet to be seen and the urgency. Requests to be addressed administratively also need to be tracked including who is responsible for addressing the request, that this individual was informed and have taken responsibility. Information on the number of requests that need to be seen and progress through the day should be communicated to MDC.	Provide documentation that the sick call list is accurate and uptodate to include evidence that sick calls are triaged appropraitely and patients are seen by an RN or provider appropriately. (it is not sufficient to show that a sick call was receieved on a certain date and triaged)			12/31/2022		

	3	The daily operational huddle should be used to manage the work flow needed to respond to requests for health care attention.	The DON or delegated charge nurse should obtain a report of the number of health requests received, the number that are emergent, urgent, routine and administrative and discuss this at the daily operational huddle to include identification of staffing necessary to accomplish timely response to each. Any issues that may affect timely completion are identified and steps to address the problem, assigned and initiated. Mid shift or mid day and at the end of the shift or workday the DON or charge checks the progress completing scheduled sick call encounters and takes action necessary to ensure timely response. If custody operations is contributing to delay the DON makes immediate contact with their custody counterpart to request assistance. At the end of the workday the number of requests that are left to be seen or addressed is provided and incorporated into the operational plan for the next day.	1. Accurate reports will be completed , daily huddles will occur. 2. Sick call Lists and daily sign-in sheets will be provided to Expert and Plaintiffs on montly basis.			12/31/2022		
Treatment protocols and tools are not consistently used and nursing assessments are not comprehensive or detailed.	4	Assess the competency of nurses conducting sick call.	Nurses should have access to the electronic record when seeing patients so that the NET & ERT template is used to achieve more comprehensive documentation. Provide evidence that nurses have been trained and demonstrate competency in triage decision making, history and assessment of complaints and common medical conditions, and decisions on the disposition of the complaint.	1. Nurses have access to electronic records when seeing patients. 2. All nurses, including agency nurses, demonstrate competency as described in column D			12/31/2022		

	5	Evaluate the quality and completeness of nursing assessments.	Develop a tool to evaluate the quality of nursing assessments and appropriateness of clinical decisions with emphasis on correct use of the NETs and ERTs. Audit should include observation and skill demonstration as well as chart review. Audits samples should be comprised of at risk patients. Individual nurses should receive regular feedback for continuous improvement. Aggregate results of these audits are also trended to identify subjects for additional training and development.	See Column D.			12/31/2022		
Lack of privacy for sick call encounters.	6	Address the lack of privacy and other issues with sick call encounters taking place in the housing units.	Evaluate sick call encounters taking place on the housing units to determine what steps to improve privacy are necessary. This evaluation should also address the tools and equipment necessary to conduct a history and assessment consistent with the NETs and ERTS and contemporaneous documentation in the electronic record. Establish a plan of correction. Seek necessary support for the changes from MDC.	Sick call encounters are sufficiently private to complete and document an appropriate history and assessment consistent with written guidelines.			12/31/2022		

Medication Management									
Issue	Task #	Task	Process For Accomplishing The Task	Expectation	Responsible Party	Start Date	Deadline	Percentage Complete	Completion Date
Patients do not have needed medication initiated timely, medications are missed or discontinued that should not be, medication is administered untimely, providers are not notified of non-adherence.	1	Re-evaluate medication management processes and identify problems that occur with current practices.	a. Make a list of current medication practices that are problematic. It appears that these include medication verification at intake and upon return from off-site care, delays in initiation of medication treatment upon intake and off site care, delays to first dose of ordered medication, continuity of medication especially when a renewal order is needed, timeliness of medication administration and documentation of doses administered, missed and refused. b. For each of the problem areas identified map the process and identify the factors that contribute to the likelihood that a problem will occur. For example does the practice of batching verbal and telephone orders contribute to delays in first dose because of timeframes used by pharmacy to package medication. Are appropriate stock medications available etc. How does non-formulary review contribute to delays or discontinuity of important medications? c. Identify changes in the process that would correct or mitigate each problem, identify equipment or supplies that would address each problem etc. d. Draft the recommended changes into a plan, identify the information needed to know if the change worked, share the problem and plan with affected staff and enlist their buy-in, provide training, equipment and supplies needed as a result of the changed process, implement and measure the change. e. Progress toward improvement needs to be measured and communicated to staff and leadership.	Necessary medications are initiated and continued. Processes set out in Column D are accomplished and documentation provided to Plaintiffs and Expert.			12/31/2022		
	2	Request technical assistance with this review from a systems engineer or process improvement specialist (someone certified in Lean/Six Sigma). This person and Corporate can begin work on task 1 and 3 now.	Medication management is dependent on and impacts many different parts of the health care program and the jail operation. It also carries significant risk to patient safety and is expected to comply with pharmacy regulations. Most health care programs do not have the internal expertise to address the complexity of this process. The improvement process should also consider technical and equipment solutions to improve timeliness and accountability such as automated dispensing, provider order entry etc.	Request and obtain technical assistance as set out in column C. This assistance can be provided by an outside consultant or appropriate YesCare employee.			12/31/2022		
	3	Establish information needed to manage medication workflow.	a. Evaluate information flow in medication management and automate as much of this workflow as possible. For example, are providers prompted automatically for medication renewals, are providers notified of consecutive refusals automatically based upon the MAR. Is patient location accurate when medications are due? What report is available to show medication not that needs to be administered or not administered? b. Define what information is needed by staff to perform the work required and build processes to automate this as much as possible.				12/31/2022		

When processes change staff are not adequately informed or trained.	4	Determine what training or information needs to be provided various personnel and provide it.	When processes change, management determines what training and other resources are needed by staff to carry out the new methods. There is a plan and timeframes to accomplish this. Progress toward staff readiness is reported at weekly leadership meetings. Staff proficiency in performing changed procedures is evaluated. There is documentation of demonstrated competency.	Competency to perform changed processes is demonstrated and documented.			12/31/2022		
	5	Develop tools to audit medication administration.	Develop an observation tool to audit medication administration against the steps in the facility specific policy and procedure. Audit medication administration to identify system challenges and performance practices that cause deviation from P & P. Use results of audits to provide feedback and coaching for individual staff and aggregate results with trending and analysis for CQI. Another tool should be developed to audit whether documentation on the MAR was correct and complete. The input and approval of the Monitor should be sought in the development of criteria measured and sample selection instructions.	Unsafe practices in medication administration and documentation are identified and addressed. Audit tool for medication administration developed and in use.			12/31/2022		
	6	Develop tools to audit a. timeliness to first dose at intake and after new orders are received, b. medication continuity for refills and renewals, and c. notification to providers of refusals and steps taken by providers to address non-adherence.	Facility specific policies and procedures should serve as the basis for the criteria in these audit tools. The input and approval of the Monitor should be sought in the development of criteria measured and sample selection instructions. Use results of audits to provide feedback and coaching for individual staff and aggregate results with trending and analysis for CQI.	Barriers to timely, safe medication management are identified and addressed. Audit tool developed and in use			12/31/2022		
Monitor and manage workflow associated with medication management.	7	Pertinent information is available and used by leadership to manage the workflow of medication management.	Establish performance metrics for time from last dose of substance to first dose of withdrawal medication, time from order to first dose of other medications, orders not yet processed, delayed delivery of medication to the facility, delays or missed doses of medication administered, refills or new orders needed but not complete. Develop reports that can be reviewed and discussed by leadership and mangers at the daily operational huddle and adjustments made to address missing or delayed medication treatment. Some of this information is also needed for the change of shift report. Clear parameters are defined for when escalation up the chain of command is to take place.	Provide performance metrics and begin providing reports.			1/23/2023		

Chronic Medical Conditions									
Issue	**Task #**	**Task**	**Process For Accomplishing The Task**	**Expectation**	**Responsible Party**	**Start Date**	**Deadline**	**Percentage Complete**	**Completion Date**
There is no organized chronic care program	1	Until the Site Medical Director position is filled appoint a physician responsible to initiate and manage the chronic care program at MDC.	1. Assign or appoint a physician within the vendor's network to manage CC at MDC. 2. Finalize the policy and procedure for chronic care at MDC. Finalize clinical practice guidelines used for chronic care. Evaluate current resources and personnel to accomplish CC consistent with the P & P and guidelines. Identify additional resources that may be needed and incorporate into a plan with benchmarks and deadlines to complete. 3. Provide education, training, coaching or technical assistance for staff assigned to CC. 4. Consider establishing a telehealth chronic care clinic in the interim while two FTE physician positions are vacant to take workload off the two nurse practitioners.	Complete each enumerated process and implement a functioning chronic care program			12/31/2022		
	2	Evaluate and establish the accuracy of the chronic care roster.	Depending upon what was provided at the time of the transition (was a chronic care roster provided or was it only of those persons detained at the time?) the vendor's roster of CC patients will not be accurate unless the Sapphire record has been reviewed to identify if the person had a chronic condition. The vendor should review the records in Sapphire of any detainee currently in population to determine if they were being followed in CC by the previous vendor. The Sapphire record also needs to be reviewed as part of intake screening going forward. Also review whether there are people identified as CC who do not need to be enrolled.	The chronic care roster is accurate and kept up to date to include all patients with documented chronic conditions before and after YesCare obtaining the contract. Provide Plaintiffs and Expert Chronic Care roster to include Patient information, diagnoses, date of first and next chronic care visit, and other information identified by Expert and County/vendor			12/31/2022		
Chronic care encounters are not timely (initial and follow up).	3	Establish a schedule of chronic care appointments that results in timely CC encounters.	Based upon current population determine how many CC appointments need to take place each week in order to maintain timeliness. Assign staff necessary to accomplish the CC workflow. Establish metrics to monitor the workflow of CC (e.g. if a clinic is cancelled how soon are they to be rescheduled).	Appointments for CC are timely. Provide metrics to Expert and Plaintiffs.			12/31/2022		

	4	Manage the workflow of chronic care.	The daily operational huddle (see Tab 4, Ln 2) should be used by leadership to review the number of CC appointments scheduled to take place that day, identify any barriers to completing these appointments (lack not done, transport issues etc.), and any backlog. Adjustments to the schedule, assignments, needed notifications or other steps are identified to address barriers and personnel assigned to address each step. Issues not resolved from the day before are also reported and additional steps identified.	Leadership is aware of and intervenes to remove barriers to CC workflow. Sign in sheets from daily huddle provided to Expert and Plaintiffs; chronic care clinic calendar provided to Expert and Plaintiffs on a monthly basis.			12/31/2022		
CC evaluations are not comprehensive or consistent with clinical practice guidelines.	5	Evaluate the quality of clinical documentation	Evaluate current documentation templates and revise as necessary to ensure that they support clinician expectations for documentation of CC clinical practice guidelines. Evaluate CC workflow to identify steps or processes that could be eliminated or streamlined to support the provider completing a thorough and comprehensive CC visit. Evaluate provider proficiency with CC expectations.	CC encounters are consistent with the CC Policy & Procedure and Clinical Guidelines. Provide documentation of evaluations to Expert and Plaintiffs			12/31/2022		
	6	Audit the quality and timeliness of CC.	Use the Monitor's report and recommendations regarding chronic care to develop an audit tool that evaluates the timeliness of initial and follow-up care, completion of diagnostic testing, and implementation of orders. The audit also needs to evaluate whether clinical guidelines were followed, the reason for deviation documented and the appropriateness of clinical decisions about the patient's condition and follow up. Audit results should be provided in feedback to individual clinicians and in aggregate to CQI with trending and analysis. The Monitor should approve the audit tool, including sample selection and audit frequency.	Audit the quality and timeliness of CC.			12/31/2022		

	7	Implement case management practices into the CC program	Individuals responsible for chronic care meet to review more complex cases in a multidisciplinary meeting. Complex cases includes patients with mental health co-morbidities, frail/elderly persons especially those with multiple CC conditions, high acuity conditions, and those whose condition is considered poor or deteriorating. This meeting includes staff most involved with the patient and may include custody, classification, discharge planners, and others. The frequency each patient's care is reviewed is based upon their current clinical status and disease progression.	Difficult or complex patient care is managed by an interdisciplinary team through implementation of case management practices in the CC program. Document interdisciplinary meeting notes in corresponding patient files as a file review and document meeting was held on CC list.	This could be started now although membership may change over time. H.S.A. should be responsible for leading the meeting and ensuring the appropriate parties are included including MH.		12/31/2022		

H & P									
Issue	**Task #**	**Task**	**Process For Accomplishing The Task**	**Expectation**	**Responsible Party**	**Start Date**	**Deadline**	**Percentage Complete**	**Completion Date**
The initial and periodic health assessment is not completed timely nor is it thorough.	1	Conduct a root cause analysis to determine reasons for the lack of detail and insufficient plans of care in the initial and periodic health assessments.	Map the current and desired process to complete H & Ps. Assess the training and degree of clinical supervision provided to develop skills to perform H & Ps. Assess the physical location, tools available and privacy provided for H & Ps. Evaluate the template used to document the health assessment. Use results of the root cause analysis to identify interventions which will improve comprehensiveness and detail in H & Ps.	The initial health appraisal is comprehensive and the plan of care is appropriately detailed.			12/31/2022		
	2	Establish or obtain a report that tracks initial and periodic health appraisals.	Review the report daily to identify appraisals that need completion and schedule staff to complete them based upon prioritization of need.	Initial and periodic health appraisals are completed timely.			12/31/2022		
	3	Report progress with completion of health appraisals at the daily operational huddle.	The DON should review the report in advance of the daily operational huddle and prepare to report the plan for that day, any expected obstacles, back up plans, remediation necessary from the day before, and help needed or alerts necessary.	Workflow is managed and monitored so backlogs are not created. Provide documentation that reports are generated and reviewed by DON or designee.			12/31/2022		
	4	Develop and implement a plan to address the backlog of appraisals that are overdue. The plan needs to include deadlines and targets to completion.	Schedule staff and appointments for H & Ps to eliminate the backlog. Work with custody staff in developing this plan to ensure access to patients. The scheduling of these appraisals is also based upon a prioritization of need. Report progress at weekly meetings with MDC.	The backlog of health appraisals is eliminated. Provide plan to Expert and Plaintiffs. Provide backlog report from date of offer and backlog report 60 days from offer. Provide monthly H&P reports to include H&Ps completed, timeliness, and backlog.			To be completed in Qtr. 4 - by 1/1/23		